

# Adolescent Treatment: Its History and Current Renaissance

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The United States experienced a number of troubling drug trends during the past decade. Most prominent among these trends was a surge in youthful polydrug use (cannabis, stimulant, hallucinogen, sedative), a rise in juvenile opiate addiction, and changing patterns of youthful binge drinking. The 1990s witnessed shifts in drug tastes and availability that brought old and new drugs onto the psychoactive drug menu: LSD, methamphetamine, "club drugs" (MDMA/Ecstasy, GHB, rohypnol), and dissociative anesthetics (PCP, ketamine). Respondents in the latest national school survey reported particularly high rates of binge drinking (consuming five or more drinks in a row in the past thirty days): 15 percent of 10th graders, 26 percent of 11th graders, and 31 percent of 12th graders. The most disturbing and historically significant of these trends was the lowered age of regular onset of alcohol and other drug use.

Shifting patterns of youthful drug consumption were evident in a number of data sources: alcohol- and drug-related deaths, emergency room admissions, arrest and incarceration rates, and treatment admissions. Particularly important for the addiction counselor was the fact that, between 1994 and 1999, the number of persons aged 12 to 17 admitted to addiction treatment in the U.S. increased 20 percent (SAMHSA, Treatment Episode Data Set Report).

Today's addiction counselor is more likely to see adolescents within his or her caseload and see adults whose relationship with alcohol and other drugs began before or during early adolescence. The resurgence in adolescent illicit drug use and binge drinking has sparked renewed calls for evidence-based intervention programs for substance-involved youth and their families. This article reviews the history and future of such interventions.

## **Drunkard children (1780-1900)**

Children regularly consumed (diluted) alcohol in Colonial America, and youth in some Native American tribes experienced shaman-guided, drug-facilitated rights of passage into adulthood. What did not occur in the 17th and 18th centuries was widespread misuse of alcohol or other drugs by young people. As per capita alcohol consumption skyrocketed among all Americans between 1780 and 1820, concern grew about youthful alcohol misuse, particularly among orphaned children. An emerging temperance movement responded by:

- \* lobbying for minimum drinking age and temperance education laws,
- \* publishing youth temperance literature,
- \* including young people in temperance society activities, and
- \* suppressing drinking on college campuses (Mosher, 1980).

Nineteenth century recovery-support societies sponsored "cadet" branches for young inebriates and launched "youth rescue" crusades. Many of the recovered alcoholics who led these efforts had themselves started their downfall as youth. One even became known on the temperance lecture circuit as the "saved drunkard boy" (Foltz, 1891). Young people were also included within America's first addiction treatment institutions. Alcoholics between the ages of 15-20 constituted nearly 10 percent of admissions to 19th century inebriate homes and inebriate asylums. By the 1890s, patients as young as 12 years old were being admitted for hospital detoxification even as adolescent alcohol use was dramatically declining (White, 1998). By the end of the 19th century, most American youth were protected from significant exposure to alcohol and other drugs, and youth in large numbers were enlisted in the movement to legally prohibit alcohol and other drugs.

### **Treating juvenile narcotic addiction (1910-1950)**

Two trends sparked interest in the treatment of drug- and alcohol-involved youth in the early 20th century. The first was the advent of opiate use among disaffiliated urban youth (Musto, 1974). This trend spurred rising juvenile arrests and the rejection in the thousands of World War I draftees due to heroin addiction (Terry and Pellens, 1921). The second trend was the reversal of the decline of alcohol consumption among children and adolescents. Prohibition (1920-1933) produced a decrease in most alcohol-related problems through the mid-1920s, but generated an unintended interest in alcohol among young people. By the end of the 1920s, drinking and smoking had become symbols of youthful liberation and rebelliousness.

Efforts to treat adolescent addicts occurred in several settings. Juveniles were represented among the clientele of the morphine maintenance clinics that operated in the U.S. between 1919 and 1924. Of the more than 7,500 addicts registered at the Worth Street Clinic in New York City, 743 were under the age of 19 (Hubbard, 1920). New York City also established Riverside Hospital as a specialized facility for treating narcotic addiction, but it was closed after it was discovered that most addicts quickly relapsed following their release (Copeland, 1920).

By the mid-1920s, most juvenile addicts were "treated" in municipal correctional institutions, their incarceration a testament to the growing belief in the incurability of addiction. By the time two "narcotic hospitals" were opened in Lexington, Kentucky (1935) and Fort Worth, Texas (1938), the earlier epidemic of juvenile

narcotic addiction had abated.

What occurred between 1900 and 1950 was first the inclusion of adolescents within new approaches to the treatment of narcotic addiction and then the collapse of nearly all such treatment. From the closing of Riverside Hospital to the channeling of most addicts to the two federal prison-hospitals, adolescent addicts entering treatment were viewed as miniature versions of adult addicts and were mainstreamed via the indiscriminate application of adult treatment methods.

### **Community-based adolescent treatment (1950-1990)**

Following two decades of abeyance, juvenile narcotic addiction rose dramatically in the early 1950s, particularly within urban African-American and Puerto Rican neighborhoods. Admissions of persons under age 21 to the two U.S. Public Health Hospitals rose from 22 in 1947 to 440 in 1950. Juveniles were seeking help at local hospitals in many communities, particularly in New York City, where two city hospitals admitted 340 teenage narcotic users between January and October 1951 (*Conferences*, 1953). The lack of community resources to help young addicts spurred the opening of addiction wards within some urban hospitals. Churches also became involved in youth addiction ministries during the 1950s, creating such programs as St. Mark's Clinic in Chicago, the Addicts Rehabilitation Center in Manhattan, the Astoria Consultation Service in Queens, and Exodus House in East Harlem. These were followed by other religiously affiliated programs like Teen Challenge and the Samaritan Halfway House Society in the early 1960s (White, 1998).

The re-opening of Riverside Hospital in July 1952 as a treatment facility exclusively for juvenile addicts, marks the birth of specialized adolescent treatment. This 140-bed facility and its multidisciplinary staff offered detoxification; psychiatric and medical evaluations; psychological testing; individualized programs of therapeutic, educational, vocational and recreational activities; and outpatient follow-up via community clinics following three-to-six months of inpatient treatment.

In spite of its "state-of-the-art" status, Riverside was closed in 1961 after a follow-up study of 247 former patients documented that 97 percent of the juveniles treated at Riverside returned to heroin use following their discharge (Gamso and Mason, 1958).

Other mid-century events that influenced the future evolution of adolescent treatment included the development of "young peoples' meetings" within Alcoholics Anonymous and Narcotics Anonymous, the development of modified therapeutic communities for adolescents, and the appearance of adolescent chemical dependency programs based on the "Minnesota Model." Through the 1960s, 70s and 80s, the treatment of adolescent substance use disorders continued to be provided primarily in adult substance use units using adult models. These programs were often developmentally inappropriate and were not

adapted to adolescent patterns of substance use, particularly the high rates of co-occurring problems. Not surprisingly, treatment outcomes for adolescents revealed less success than those achieved by adults (Craddock, Bray, and Hubbard, 1985; Dennis et al., in press; OAS, 1995; Sells and Simpson, 1979).

### **The modern era**

Starting slowly in the 1980s and early 1990s, several scattered groups of clinical programs, state funding agencies and addiction researchers started modifying treatment models to be more developmentally appropriate for adolescents by:

- \* using youth-oriented, multi-dimensional assessment instruments,
- \* developing youth-focused family and group treatment modalities,
- \* using younger and more educated staff at agencies and hospitals,
- \* dealing more flexibly with rule violations,
- \* shifting from confrontation to motivation/engagement,
- \* coordinating care with schools and the juvenile justice systems,
- \* defining clinical subpopulations requiring special approaches of engagement and treatment (e.g., ethnic minorities, runaways, and adolescents with conduct disorder, ADHD, depression, HIV/AIDS and other co-occurring disorders), and
- \* refining the use of pharmacological adjuncts in the treatment of co-morbid conditions.

The Center for Substance Abuse Treatment (CSAT) sought to spread these innovations through a series of widely distributed Treatment Improvement Protocols.

The rate of clinical and research advances in the field of adolescent treatment accelerated rapidly at the end of the 20th century. Of the 36 empirical studies of adolescent treatment published by the end of 2001, 22 were published after 1997. The total number of such studies will more than double in the next few years.

### **The emerging renaissance of adolescent treatment**

This emerging renaissance of adolescent treatment promises to continue for many years. In addition to the studies already in the field, there are several major initiatives just getting underway. CSAT is funding several five-year studies to develop and evaluate community-based efforts to create continuum of care models for adolescents that include linkage to schools and juvenile justice agencies. CSAT and NIDA are collaborating on studies of continuing care after adolescent residential treatment. The Robert Wood Johnson Foundation is funding a guide to adolescent treatment and several demonstrations linking

treatment with the juvenile justice system. NIDA/NIAAA are also continuing to fund several individual grants related to individual aftercare. It is expected that elements of the infrastructure of such studies will also be increasingly mainstreamed, e.g., standardized assessment, competency-based training, treatment manuals, and model fidelity instruments/procedures, and rigorous clinical supervision.

In addition, it is anticipated that adolescent treatment in the coming decades will make major advances in such areas as early intervention strategies, clinical engagement and retention techniques, and the ability to match particular interventions to particular subpopulations of clients. Perhaps most significantly, we anticipate that the treatment of adolescent substance use disorders will shift (for those adolescents presenting patterns of high problem severity and complexity) from sequential, self-encapsulated episodes of acute care (assess, admit, treat, discharge) to a more time-sustained, community support model of recovery management. This will integrate existing clinical approaches within a deeper understanding of the social and cultural ecology of adolescent recovery. The treatment of adolescent substance use disorders is moving from the status of a folk art to that of a science-guided endeavor.

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